



Dental History

1. Date of Last Dental Visit: _____ Reason for this Visit: _____
2. Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
3. Do you have any concerns about previous dental care or this dental visit? Yes No
If yes, please explain: _____
4. Do your gums bleed? Yes No
5. Are your teeth loose? Yes No
6. Have you ever been told that you have bad breath? Yes No
7. Are your teeth sensitive to (circle all that apply) Sweets Cold Heat Pressure
9. Do you feel your teeth are starting to get longer? Yes No
10. Do you get food stuck between your teeth easily? Yes No
11. Do you ever experience tooth pain that is relieved by biting down on the affected area? Yes No
12. What would you change about the condition of your mouth? _____

13. Please check any statement that you agree with about your smile:
 - I wish my teeth were whiter.
 - I wish I had a bigger smile.
 - I think some of my teeth are too small.
 - I think some of my teeth are too large.
 - I wish my teeth were straighter.
 - My gums show too much when I smile.
 - I think there is too much space between some of my teeth.
 - Because I am not totally pleased with my smile, I sometimes hesitate to smile.
 - I have often wished I could change some of the features of my smile.
 - I think I need to do a better job of protecting the health of my smile.

Signature of Patient, Parent or Guardian

Date